COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDAROS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

August 6, 2010

Louis Kraml, Administrator
Bingham Memorial Hospital
P.O. Box 751
Blackfoot, ID 83221

Provider #131325

Dear Mr. Kraml:

On **July 21, 2010**, a complaint survey was conducted at Bingham Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004615

Allegation #1: A physician slapped a patient while he was in ICU (Intensive Care Unit), after brain surgery and was was verbally rude to the patient's wife.

Findings #1: An unannounced visit was made to the hospital on 7/14/10 to 7/15/10. In addition, a phone consultation with senior staff was conducted on 7/21/10. During the complaint investigation, surveyors interviewed staff, reviewed hospital policies and procedures, a root cause analysis, administrative meeting minutes (Medical Executive Committee and Governing Body), medical staff bi-laws, a peer review case, and seven patient occurrences/concerns/complaints.

Of the complaints reviewed (all received in the past 6 months), only one involved an allegation of physician abuse of a patient. The following information relates to the allegation of physical abuse and an associated allegation that the physician was also verbally inappropriate toward the patient's wife:

An Occurrence form, completed by a registered nurse, dated 3/05/10 at 8:24 PM,

stated a physician entered the room of a patient who was agitated and crying out in pain. It further documented the physician "began vigorously stimulating pt. (patient) using chest slap x (times) 2 and a facial slap."

A second Occurrence form, dated 3/06/10, was completed by a family member of the patient (described in the previous paragraph). In the complaint, the family member complained that in addition to the occurrence described above, the physician responded inappropriately to her request for an explanation as to why the surgery took longer than anticipated. The physician allegedly responded "...they were having such a 'good time' and they were giving (patient's name) the 'Cadillac treatment,' and it was one of the last times he'll be doing surgery with (physician name)-so they wanted to draw it out longer."

The Occurrence reports were logged on 3/06/10, received by the CEO on 3/08/10, and subsequently routed to the Risk Management Department and to the Chief of Staff.

The Chief of Staff wrote a memo on 3/10/10 indicating he met with the patient's wife on 3/06/10. The meeting also included the patient's attending physician and the charge nurse involved with the patient's care.

The hospital documented conducting a thorough investigation (called a root cause analysis) on 3/06/10 through 3/10/10 of the events that occurred on 3/05/10 as described in the above referenced allegations.

A written statement from the acused physician, dated 3/14/10, was addressed to the Chief of Staff of the hospital. It stated, "The standard neurosurgical examination of a compromised patient involves observation of a patient's response to verbal and painful stimuli. The post operative examination of the patient referenced in the 'care concern' was conducted within the standard. The neurosurgical exam, although simple and direct, is a powerful tool in the assessment of the neurologically impaired and in the case in question allowed for a determination that an impending neurologic crisis was not at hand."

Surveyors interviewed the physician on 7/16/10 starting at 8:30 AM. The physician explained the patient responded normally immediately after surgery but later in the day had a change in status, as reported by an RN. The physician was called to re-evaluate the patient when the patient was not able to obey commands. When the physician arrived to see the patient, the patient was making incomprehensible sounds, had rigid posture, and was not able to follow commands. The physician expressed

concern the patient could have been having a neurological emergency, such as seizures, and/or lapsing into a coma. He felt it necessary to perform a neurological exam that included speaking loudly, vigorous and painful stimulation of the patient, including chest slaps, pinching, and facial slapping (after stabilizing the head). He stated this type of exam helped the physician evaluate if the patient was lapsing into a coma. He explained he had been trained 20 years prior in this type of examination. He expressed regret a family member had to see him perform this type of exam but, nevertheless, felt it was necessary for the care of the patient to adequately assess his neurological status, using vigorous stimulation and painful stimuli. He stated after performing the exam, the patient's wife became upset. In response to the sound of his wife's voice, the patient began to speak normally and continued to act normally for the rest of the hospitalization. The physician expressed relief at the patient's recovery and good outcome. He explained that after the incident, senior hospital staff told him not to do that type of stimulation again until the Medical Executive Committee met, evaluated the practice, and decided what was acceptable practice in these circumstances. He agreed to avoid this type of stimulation again unless he received approval from senior hospital staff.

He stated the comments to the patient's wife regarding the "Cadillac treatment" were mostly true. The physician stated he did not have another surgery waiting and he was able to take his time with the patient. He explained his comments were intended to inform the patient's wife that they took their time and ensured the patient was well cared for. He stated often surgeries take longer than expected and prep and post operative times also slow down the processes. He stated this was the case for the above patient.

The Medical Executive Committee met and reviewed the case on 3/16/10, 4/20/10, and 5/18/10. In addition, the Medical Executive Committee met on 7/21/10 in a closed session to discuss the allegations further. The session notes documented that it was the opinion of the attendees of the Medical Executive Committee meeting that the attending physician did not intend in any way to maliciously harm the patient. They stated a standard needed to be developed on patient stimulation. An action plan was developed.

It could not be determined that the intention of the involved physician was to abuse a patient or be rude to the patient's spouse.

Conclusions: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The hospital did not respond to patients and/or their family's complaints.

Findings #2: An unannounced visit was made to the hospital on 7/14/10 to 7/15/10. In addition, a phone consultation with senior staff was conducted on 7/21/10. During the complaint investigation, surveyors interviewed staff, reviewed hospital policies and procedures, a root cause analysis, administrative meeting minutes (Medical Executive Committee and Governing Body), medical staff bi-laws, a peer review case, and seven patient occurrences/concerns/complaints.

An Occurrence form, completed by a registered nurse, dated 3/05/10 at 8:24 PM, stated a physician entered the room of a patient who was agitated and crying out in pain. It further documented the physician "began vigorously stimulating pt. (patient) using chest slap x (times) 2 and a facial slap."

A second Occurrence form, dated 3/06/10, was completed by a family member of the patient (described in the previous paragraph). In the complaint, the family member complained that in addition to the occurrence described above, the physician responding inappropriately to her request for an explanation as to why the surgery took longer than anticipated. The physician allegedly responded "...they were having such a 'good time' and they were giving the 'Cadillac treatment,' and it was one of the last times he'll be doing surgery with-so they wanted to draw it out longer."

The Occurrence reports were logged on 3/06/10, received by the CEO on 3/08/10, and subsequently routed to the Risk Management Department and to the Chief of Staff.

A letter to the complainant, dated 7/21/10, was drafted and was to be sent to the complainant.

The hospital's Concern Process policy, last revised on 4/29/08, had a procedure for investigating and responding to complainant concerns. It was determined the hospital followed their policy.

The hospital followed its policies and responded to complainants.

Conclusions: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Teresa Hamblin

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srp